

(a) State plan requirements for excluding providers for fraud and abuse, and suspending practitioners convicted of program-related crimes.

(b) The limitations on FFP for services furnished by excluded providers or suspended practitioners.

(c) The requirements and procedures for reinstatement after exclusion or suspension.

(d) Requirements for the establishment and operation of State Medicaid fraud control units and the rates of FFP for their fraud control activities.

[51 FR 34788, Sept. 30, 1986]

Subpart A—Medicaid Agency Fraud Detection and Investigation Program

§ 455.12 State plan requirement.

A State plan must meet the requirements of §§ 455.13 through 455.23.

[52 FR 48817, Dec. 28, 1987]

§ 455.13 Methods for identification, investigation, and referral.

The Medicaid agency must have—

(a) Methods and criteria for identifying suspected fraud cases;

(b) Methods for investigating these cases that—

(1) Do not infringe on the legal rights of persons involved; and

(2) Afford due process of law; and

(c) Procedures, developed in cooperation with State legal authorities, for referring suspected fraud cases to law enforcement officials.

[43 FR 45262, Sept. 29, 1978, as amended at 48 FR 3755, Jan. 27, 1983]

§ 455.14 Preliminary investigation.

If the agency receives a complaint of Medicaid fraud or abuse from any source or identifies any questionable practices, it must conduct a preliminary investigation to determine whether there is sufficient basis to warrant a full investigation.

[48 FR 3756, Jan. 27, 1983]

§ 455.15 Full investigation.

If the findings of a preliminary investigation give the agency reason to believe that an incident of fraud or abuse has occurred in the Medicaid program,

the agency must take the following action, as appropriate:

(a) If a provider is suspected of fraud or abuse, the agency must—

(1) In States with a State Medicaid fraud control unit certified under subpart C of part 1002 of this title, refer the case to the unit under the terms of its agreement with the unit entered into under § 1002.309 of this title; or

(2) In States with no certified Medicaid fraud control unit, or in cases where no referral to the State Medicaid fraud control unit is required under paragraph (a)(1) of this section, conduct a full investigation or refer the case to the appropriate law enforcement agency.

(b) If there is reason to believe that a beneficiary has defrauded the Medicaid program, the agency must refer the case to an appropriate law enforcement agency.

(c) If there is reason to believe that a beneficiary has abused the Medicaid program, the agency must conduct a full investigation of the abuse.

[48 FR 3756, Jan. 27, 1983, as amended at 51 FR 34788, Sept. 30, 1986]

§ 455.16 Resolution of full investigation.

A full investigation must continue until—

(a) Appropriate legal action is initiated;

(b) The case is closed or dropped because of insufficient evidence to support the allegations of fraud or abuse; or

(c) The matter is resolved between the agency and the provider or beneficiary. This resolution may include but is not limited to—

(1) Sending a warning letter to the provider or beneficiary, giving notice that continuation of the activity in question will result in further action;

(2) Suspending or terminating the provider from participation in the Medicaid program;

(3) Seeking recovery of payments made to the provider; or

(4) Imposing other sanctions provided under the State plan.

[43 FR 45262, Sept. 29, 1978, as amended at 48 FR 3756, Jan. 27, 1983]